211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS

52.01: Authority

211 CMR 52.00 is promulgated in accordance with authority granted to the Commissioner of Insurance by M.G.L. c. 175, § 24B, ~~and~~ M.G.L. c. 176O, §§ 2 and 17, and M.G.L. c. 176R, § 6.

52.02: Applicability

211 CMR 52.00 applies to any carrier that offers for sale, provides or arranges for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employs utilization review in making decisions about whether services are covered benefits under a health benefit plan. A carrier that provides coverage for limited health care services only, that provides specified services through a workers' compensation preferred provider arrangement, or that does not provide services through a network or through participating providers shall be subject to those requirements of 211 CMR 52.00 as deemed appropriate by the Commissioner in a manner consistent with a duly filed application for accreditation as outlined in 211 CMR 52.06(2).

Certain requirements of 211 CMR 52.00 *et seq*., as specified, shall also apply to dental and vision carriers. Such provisions are: ~~211 CMR 52.10(2);~~ 211 CMR 52.12(1) through (4); 211 CMR 52.12(11); 211 CMR 52.12(13); 211 CMR 52.13(2), 211 CMR 52.13(3)(a), (c) through (e), (g) through (i), (m) through (p); 211 CMR 52.13(4) through (10); 211 CMR 52.14(1)(c) and (d); 211 CMR 52.14(2), (3) and (7); and 211 CMR 52.1~~8~~9.

52.03: Definitions

As used in 211 CMR 52.00, the following words mean:

Accreditation, a written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

Actively Practicing, means that a health care professional regularly treats patients in a clinical setting.

Administrative Disenrollment, a change in the status of an insured whereby the insured remains with the same carrier but his or her membership may appear under a different identification number. Examples of an administrative disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the carrier as both a disenrollment and an enrollment.

Adverse Determination, a determination, based upon a review of information provided, by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Ambulatory Review, utilization review of health care services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency facility, as well as other locations such as laboratories, radiology facilities, provider offices and patient homes.

Authorized Representative, an insured's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c. 210, family member, or other person authorized by the insured in writing or by law with respect to a specific grievance or external review provided that if the insured is unable to designate a representative, where such designation would otherwise be required, a conservator, holder of a power of attorney, or family member in that order of priority may be the insured's representative or appoint another responsible party to serve as the insured's authorized representative.

Behavioral Health Manager, a company, organized under the laws of the Commonwealth or organized under the laws of another state and qualified to do business in the Commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral health services to voluntarily enrolled members of the carrier.

Bureau of Managed Care or Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Capitation, a set payment per patient per unit of time made by a carrier to a licensed health care professional, health care provider group or organization that employs or utilizes services of health care professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that provides coverage solely for dental care services or vision care services.

Case Management, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Clinical Peer Reviewer, a physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who actively

practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical Review Criteria, the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a carrier to determine the medical necessity and appropriateness of health care services.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, §6, or his or her designee.

Complaint,

(a) any inquiry made by or on behalf of an insured to a carrier or utilization review organization that is not explained or resolved to the insured's satisfaction within three business days of the inquiry; or

(b) any matter concerning an adverse determination. In the case of a carrier or utilization review organization that does not have an internal inquiry process, a complaint means any inquiry.

Concurrent Review, utilization review conducted during an insured's inpatient hospital stay or course of treatment.

Covered Benefits or Benefits, health care services to which an insured is entitled under the terms of the health benefit plan.

Days, calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Dental Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a dental service corporation organized under M.G.L. c. 176E, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for dental care services.

Dental Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a dental carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for dental care services.

Dental Care Professional, a dentist or other dental care practitioner licensed, accredited or certified to perform specified dental services consistent with the law.

Dental Care Provider, a dental care professional or facility.

Dental Care Services~~,~~ or ~~d~~Dental ~~s~~Services, services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

Discharge Planning, the formal process for determining, prior to discharge from a facility, the coordination and management of the care that an insured receives following discharge from a facility.

Division, the Division of Insurance.

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an insured specifying the benefits to which the insured is entitled. For workers' compensation preferred provider arrangements, the evidence of coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.

Facility, a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Finding of Neglect, a written determination by the Commissioner that a carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

Grievance, any oral or written complaint submitted to the carrier that has been initiated by an insured, or the insured's authorized representative, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 105 CMR 128.000.

HMO, a health maintenance organization licensed pursuant to M.G.L. c. 176G.

Health Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Unless otherwise noted, "health benefit plan" shall not include a dental benefit plan or a vision benefit plan.

Health Care Professional, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with the law.

Health Care Provider or Provider, a health care professional or facility.

Health Care Services or Health Services, services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Incentive Plan, any compensation arrangement between a carrier and health care professional or licensed health care provider group or organization that employs or utilizes services of one or more licensed health care professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to insureds of the organization. "Incentive plan" shall not mean contracts that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with 211 CMR 52.00.

Inquiry, any communication by or on behalf of an insured to the carrier or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of the carrier.

Insured, an enrollee, covered person, insured, member, policy holder or subscriber of a carrier, including a dental or vision carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under review, or any other individual whose care may be subject to review by a utilization review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

JCAHO, the Joint Commission on Accreditation of Healthcare Organizations.

Licensed Health Care Provider Group, a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a licensed health care provider group only if it is composed of individual health care professionals and has no subcontracts with licensed health care provider groups.

Limited Health Service, pharmaceutical services, and such other services as may be determined by the Commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the limited health services set forth in the preceding sentence.

Managed Care Organization or MCO, a carrier subject to M.G.L. c. 176O.

Material Change, a modification to any of a carrier's, including a dental or vision carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured carrier, including a dental or vision carrier, or health, dental or vision care provider.

Medical Necessity or Medically Necessary, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence.

National Accreditation Organization, JCAHO, NCQA, URAC, or any other national accreditation entity approved by the Division that accredits carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

NCQA, the National Committee for Quality Assurance.

NCQA Standards, the Standards and Guidelines for the Accreditation of Health Plans published annually by the NCQA.

Network, a group of health, dental or vision care providers who contract with a carrier, including a dental or vision carrier, or affiliate to provide health, dental or vision care services to insureds covered by any or all of the carrier's, including a dental or vision carrier's or affiliate's plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

~~NCQA, the National Committee for Quality Assurance.~~

Nondiscriminatory Basis, a carrier shall be deemed to be providing coverage on a nondiscriminatory basis if its plan does not contain any annual or lifetime dollar or

unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

Nongatekeeper Preferred Provider Plan, an insured preferred provider plan approved for offer under M.G.L. c. 176I which offers preferred benefits when a covered person receives care from preferred network providers but does not require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

Nurse Practitioner, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, §80B and regulations promulgated thereunder.

Office of Patient Protection, the office in the Department of Public Health established by M.G.L. c. 111, § 217(a).

Participating Provider, a provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier, including a dental or vision carrier.

Preventive Health Services, any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

Primary Care Provider, a health care professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes health care services, initiates referrals for specialist care, and maintains continuity of care within the scope of his or her practice.

Prospective Review, utilization review conducted prior to an admission or a course of treatment. The term “prospective review” shall include any pre-authorization and pre-certification requirements of a carrier or utilization review organization.

Religious Non-medical Provider, a provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Retrospective Review, utilization review of medical necessity that is conducted after services have been provided to a patient. The term "retrospective review" shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Same or Similar Specialty, the health care professional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the grievance. Such experience shall extend to the treatment of children in a grievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is medically necessary.

Second Opinion, an opportunity or requirement to obtain a clinical evaluation by a health care professional other than the health care professional who made the original recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.

Service Area, the geographical area as approved by the Commissioner within which the carrier, including a dental or vision carrier, has developed a network of providers to afford adequate access to members for covered health, dental or vision services.

Terminally Ill or Terminal Illness, an illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

URAC, the American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Utilization Review, a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Utilization Review Organization, an entity that conducts utilization review under contract with or on behalf of a carrier, but does not include a carrier performing utilization review for its own health benefit plans. A behavioral health manager is considered a utilization review organization.

Vision Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for vision care services.

Vision Care Professional, an ophthalmologist, optometrist or other vision care practitioner licensed, accredited or certified to perform specified vision services consistent with the law.

Vision Care Provider, a vision care professional or facility.

Vision Care Services~~,~~ or V~~v~~ision ~~s~~Services, services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

Vision Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for vision care services.

52.04: Accreditation of Carriers

(1) A carrier must be accredited according to the requirements set forth in 211 CMR 52.00 in order to offer for sale, provide, or arrange for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employ utilization review in making decisions about whether services are covered benefits under a health benefit plan.
(2) Accreditation granted to carriers pursuant to 211 CMR 52.00 shall remain in effect for 24 months unless revoked or suspended by the Commissioner.
(3) A carrier shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring accreditation of the carrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.04(3), the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited.

(b) A carrier granted an exemption pursuant to 211 CMR 52.04(3) shall be provisionally accredited and, during such provisional accreditation, shall be subject to review not less than every four months and shall be subject to those requirements of M.G.L. c. 176O and 211 CMR 52.00 as deemed appropriate by the Commissioner.

(c) Before the end of each four-month period specified in 211 CMR 52.04(3)(b) the Commissioner shall review the carrier's exemption.

1. If the Bureau determines that the carrier has met the requirements of 211 CMR 52.00, then the carrier shall be accredited and the exemption shall expire upon accreditation.
2. If the Commissioner determines that the carrier's exemption should

be continued, the Commissioner shall communicate that determination in writing to the Attorney General and the Commissioner of Public Health. Continuation of the exemption shall be granted only upon a written decision by the Commissioner, the Attorney General and the Commissioner of Public Health.

52.05: Deemed Accreditation

(1) A carrier may apply for deemed accreditation. A carrier that applies for deemed accreditation may be deemed to be in compliance with the standards set forth in 211 CMR 52.00 and may be so accredited by the Bureau if it meets the following requirements:

(a) It must be accredited by JCAHO, NCQA or URAC;

(b) It must meet all the requirements set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000; and

(c) It must have received the ratings specified in 211 CMR 52.06(5)(c) and (d).

(2) For a carrier that applies for deemed accreditation:

(a) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(c), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.08 and 211 CMR 52.09 for that applicable period.

(b) If the carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(d), the carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.10 for that applicable period.

(3) A carrier shall not be eligible for deemed accreditation status if the national accreditation organization has revoked the carrier's accreditation status in the past 24 months or the accreditation status of an entity that currently contracts with the carrier to provide services regulated by M.G.L. c. 176O.

(4) A carrier that has applied for deemed accreditation and been denied, shall be considered an applicant for accreditation under 211 CMR 52.06(3) or 211 CMR 52.06(4). Denial of a request for deemed accreditation shall not be eligible for reconsideration under 211 CMR 52.07(5).

(5) If a carrier has received accreditation from a national accreditation organization or a carrier's subcontracting organization, with whom the carrier has a written agreement delegating certain services, or has received accreditation or certification from a national accreditation organization, but under standards other than those identified in 211 CMR 52.06(5), the carrier may submit the documents indicating such accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.07(1).

52.06: Application for Accreditation

(1) Timing of Application.

(a) ~~Beginning with renewal applications effective after August 1, 2002, c~~Carriers must submit renewal applications by July 1st for renewals to be effective on November 1st.

(b) A carrier seeking initial accreditation ~~after January 1, 2001~~ must submit an application at least 90 days prior to the date on which it intends to offer health benefit plans.

(2) Inapplicability of Accreditation Requirements.

(a) A carrier that provides coverage for limited health services only, that does not provide services through a network or through participating providers or for which other requirements set forth in 211 CMR 52.06 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its health benefit plan and provide an explanation of why the carrier is exempt from each particular requirement.

(b) A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(3)(b),(e),(g),(h),(i),(j),(l), and (n). A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(4)(d) and (g).

(3) Initial Application. Any carrier seeking initial accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.06(3)(a) through (p) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;

(b) A complete description of the carrier's utilization review policies and procedures;

(c) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

(d) A copy of the most recent existing survey described in 211 CMR 52.08(10);

(e) A complete description of the carrier's internal grievance procedures consistent with 105 CMR 128.200 through 128.313 and the external review process consistent with 105 CMR 128.400 through 401;

(f) A complete description of the carrier's process to establish guidelines for medical necessity consistent with 105 CMR 128.101;

(g) A complete description of the carrier's quality management and improvement policies and procedures;

(h) A complete description of the carrier's credentialing policies and procedures;

(i) A complete description of the carrier's policies and procedures for providing or arranging for the provision of preventive health services;
(j) A sample of every provider contract used by the carrier or the organization with which the carrier contracts;
(k) A statement that advises the Bureau whether the carrier has issued new contracts, revised existing contracts, or ~~after July 1, 2001,~~ made revisions to fee schedules in any existing contract with a physician or physician group that imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(l) A copy of every provider directory used by the carrier;
(m) The evidence of coverage for every product offered by the carrier;
(n) A copy of each disclosure described in 211 CMR 52.14 and, if applicable, 211 CMR 52.15;
(o) A written attestation that the carrier has complied with 211 CMR 52.17~~6~~; and
(p) Any additional information as deemed necessary by the Commissioner.

(4) Renewal Application. Any carrier seeking renewal of accreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.06(4)(a) through (j) in a format specified by the Commissioner. Any carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.
(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;
(b) A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(c) A copy of the most recent survey described in 211 CMR 52.08(10);
(d) A sample of every provider contract used by the carrier or the organization with which the carrier contracts since the carrier's most recent accreditation;
(e) A statement that advises the Bureau whether ~~or not~~ the carrier has issued new contracts, revised existing contracts, or ~~after July 1, 2001,~~ made revisions to fee schedules in any existing contract with a physician or physician group that impose financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider. If the carrier has made any of the specified changes, the carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(f) The evidence of coverage for every product offered by the carrier that was revised since the carrier's most recent accreditation;
(g) A copy of the most recently revised provider directory used by the carrier;
(h) Material changes to any of the information contained in 211 CMR 52.06(3)(b), (e), (f), (g), (h), (i), and (n);
(i) Evidence satisfactory to the Commissioner that the carrier has complied with 211 CMR 52.17~~6~~; and

(j) Any additional information as deemed necessary by the Commissioner.

(5) Application for Deemed Accreditation. A carrier seeking deemed accreditation pursuant to 211 CMR 52.05 shall submit an application that contains the materials described in 211 CMR 52.06(5)(a) through (d).

(a) For initial applicants, the information required by 211 CMR 52.06(3).

(b) For renewal applicants, the information required by 211 CMR 52.06(4).

(c) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;

2. a score equal to or above the rating of "accredited" in the categories of utilization management, network management, quality management and member protections for the most recent review of health plan standards by URAC; or

3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.

4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of network management, quality management and member protections for the most recent review of health network standards by URAC.

(d) Proof in a form satisfactory to the Commissioner that the carrier has attained:

1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of managed care organizations, in the category of credentialing and recredentialing;

2. a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health plan standards by URAC; or

3. for nongatekeeper preferred provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the accreditation of preferred provider organizations in the category of credentialing and recredentialing.

4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health network standards by URAC.

(6) Application to be Reviewed as a Nongatekeeper Preferred Provider Plan. A carrier shall submit a statement signed by a corporate officer certifying that none of the carrier's insured plans require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level.

(7) Material Changes. Carriers shall submit to the Bureau any material changes to any of the items required by 211 CMR 52.06(3) and 211 CMR 52.06(4) at least 30 days before the effective date of the changes.

52.07: Review of Application for Accreditation

(1) The Bureau shall review all applications for accreditation according to the standards set forth in M.G.L. c. 176O, 211 CMR 52.00 and 105 CMR 128.000.

(a) For all products, ~~except nongatekeeper preferred provider plans,~~ a carrier shall not be accredited unless the carrier scores 65% or higher of an aggregate of the applicable elements in the NCQA Standards, effective July 1, 2009, for the accreditation of health benefit plans, including health maintenance organizations, gatekeeper preferred provider plans, and nongatekeeper preferred provider plans, in the categories of utilization management, quality management and improvement, and credentialing and recredentialing.~~of all the elements described in 211 CMR 52.100: *Appendix A*, 211 CMR 52.101: *Appendix B* and 211 CMR 52.102: *Appendix C* for those requirements applicable to that carrier's health plans.~~

~~(b) For nongatekeeper preferred provider plans, a carrier shall not be accredited unless the carrier scores 65% or higher of all the elements described in 211 CMR 52.110: *Appendix D*, 211 CMR 52.111: *Appendix E* and 211 CMR 52.112: *Appendix F* for those requirements applicable to that carrier's health plans.~~

(b) The NCQA Standards, effective July 1, 2009, are incorporated by reference into 211 CMR 52.00 to the extent that the NCQA Standards do not conflict with other laws of this Commonwealth. The NCQA Standards can be obtained from the NCQA.

(c) In reviewing the carrier's application for accreditation under 211 CMR 52.07, the carrier may be given credit toward the relevant score for any accreditation that it received separately or a subcontracting organization, with whom the carrier has a written agreement delegating certain services, has received accreditation or certification from a national accreditation organization for the standards described in 211 CMR 52.08, 211 CMR 52.09 or 211 CMR 52.10.

(2) A carrier's application will not be considered to be complete until all materials required by M.G.L. c. 176O and 211 CMR 52.00 have been received by the Bureau. A carrier shall respond to any request for additional information by the Bureau within 15 days of the date of the Bureau's request. A carrier that fails to respond in writing to requests within the 15 days shall be subject to the penalties described in 211 CMR 52.1~~7~~8.

(3) The Bureau may schedule, at the carrier's expense, on-site surveys of the carrier's utilization review, quality management and improvement, credentialing and preventive health services activities in order to examine records. Any on-site visit shall be scheduled within 15 days of receipt of a carrier's complete application.

(4) The Bureau shall notify a carrier in writing that it is accredited or that its application for accreditation has been denied. If an accreditation is denied, the Bureau shall identify those items that require improvement in order to comply with accreditation standards.

(5) ~~Reconsideration of a Denial~~ A carrier may seek reconsideration of a denial of its application for accreditation.

(a) A carrier whose application for accreditation has been denied may make a written request to the Bureau for reconsideration within ten days of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the carrier within ten days of the receipt of the request for reconsideration to review any additional materials presented by the carrier.

(c) Following the meeting pursuant to 211 CMR 52.07(5)(b) the Bureau may conduct a second on-site survey at the expense of the carrier.

(d) The Bureau shall notify a carrier in writing of the final disposition of its reconsideration.

52.08: Standards for Utilization Review

(1) ~~Appendices~~Standards. A carrier's application will be reviewed for compliance with ~~those~~ the applicable NCQA Standards ~~accreditation standards~~ for utilization management. ~~as set forth in 211 CMR 52.100: *Appendix A.* Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards as set forth in 211 CMR 52.110: *Appendix D.*~~ In addition, carriers shall meet the requirements identified in 211 CMR 52.08(2) through (10). In cases where the standards in 211 CMR 52.08(2) through (10) differ from those in ~~the~~ NCQA Standards~~211 CMR 52.100~~, the standards in 211 CMR 52.08(2) through (10) shall apply.

(2) Written Plan. Utilization review conducted by a carrier or a utilization review organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to:

(a) review and evaluate its effectiveness;

(b) ensure the consistent application of utilization review criteria; and

(c) ensure the timeliness of utilization review determinations.

(3) Criteria. A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities pursuant to said criteria.

(a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria consistent with 105 CMR 128.101.

(b) Utilization review criteria shall be applied consistently by a carrier or utilization review organization.

(c) Adverse determinations rendered by a program of utilization review, or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, where applicable, by a provider in the same licensure category as the ordering provider, and shall explain the reason for any denial, including the specific utilization review criteria or benefits provisions used in the determination, and all appeal rights applicable to the denial.

(4) Initial Determination Regarding a Proposed Admission, Procedure or Service. A carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information.

(a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required.

(b) In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter.

(c) In the case of an adverse determination, the carrier or the utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

(5) Concurrent Review. A carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information.

(a) In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services.

(b) In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the insured and the provider within one working day thereafter.

(c) The service shall be continued without liability to the insured until the insured has been notified of the determination.

(6) Written Notice. The written notification of an adverse determination shall include a substantive clinical justification ~~therefor~~ that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(a) identify the specific information upon which the adverse determination was based;

(b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
(c) specify any alternative treatment option offered by the carrier, if any;
(d) reference and include applicable clinical practice guidelines and review criteria; and
(e) include a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.

(7) Reconsideration of an Adverse Determination. A carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination.

(a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available within one working day.
(b) If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to 105 CMR 128.000.
(c) The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal grievance process or an expedited appeal required by 105 CMR 128.000.

(8) Continuity of Care. A carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 105 CMR 128.500 through 128.503.

(9) Workers' Compensation Preferred Provider Arrangement. A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08, except 211 CMR 52.08(9), if it has met the requirements of 452 CMR 6.00.

(10) Annual Survey. A carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.
(b) Carriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds.

(11) Religious Non-medical Treatment and Providers. Nothing in 211 CMR 52.08 shall be construed to require health benefit plans to use medical professionals or criteria to decide insured access to religious non-medical providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions

denying or limiting coverage or care by religious non-medical providers, compel an insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a religious non-medical provider, or require health benefit plans to exclude religious non-medical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the provider.

52.09: Standards for Quality Management and Improvement

(1) StandardsAppendices. A carrier's application will be reviewed for compliance with those the applicable NCQA accreditation sStandards for quality management and improvement. as set forth in 211 CMR 52.101: *Appendix B.* Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in 211 CMR 52.111: *Appendix E.*

(2) Workers' Compensation Preferred Provider Arrangements. A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.09 if it has met the requirements of 452 CMR 6.00.

52.10: Standards for Credentialing

(1) A carrier's application will be reviewed for compliance with those the applicable NCQA accreditation sStandards for credentialing and recredentialing. as set forth in 211 CMR 52.102: *Appendix C.* Nongatekeeper preferred provider plan products will be reviewed for compliance with those NCQA accreditation standards set forth in 211 CMR 52.112: *Appendix F.*

(2) A carrier shall not be required to meet the requirements of 211 CMR 52.10 if the carrier does not provide benefits through a network or does not have contracts with participating providers.

(3) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.10 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.11: Standards for Preventive Health Services

(1) A carrier's application will be reviewed for compliance with preventive services mandated by applicable law. A carrier that is not an HMO shall be required to comply with 211 CMR 52.11 only to the extent of those preventive health services mandated by its licensing or enabling statute.

(2) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.11.

52.12: Standards for Provider Contracts

(1) Contracts between carriers and providers shall state that a carrier shall not refuse to contract with or compensate for covered services with an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or

(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

(2) Contracts between carriers and providers shall state that the provider is not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.

(3) No contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

(a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to providers or which are made with respect to groups of insureds if such contracts, which impose risk on such providers for the costs of care, services and equipment provided or authorized by another health care provider, comply with 211 CMR 52.12(4).

(4) No carrier may enter into a new contract, revise the risk arrangements in an existing contract, or ~~after July 1, 2001,~~ revise the fee schedule in an existing contract with a health care provider which imposes financial risk on such provider for the costs of care, services or equipment provided or authorized by another provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection;

(b) minimum patient population size for the provider group; and

(c) identification of the health care services for which the provider is at risk.

(5) Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause.

(6) Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

(7) Contracts between carriers and health care providers shall state that the carrier shall notify providers in writing of modifications in payments, modifications in covered services or modifications in a carrier's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.

(8) Contracts between carriers and health care providers shall state that providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(9) Contracts between carriers and health care providers shall prohibit health care providers from billing patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

(10) Contracts between carriers and health care providers shall require providers to comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

(11) Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.

(12) Nothing in 211 CMR 52.12 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

(13) For dental and vision benefit plans: The following provisions regarding the standards for provider contracts found at 211 CMR 51.12, shall apply dental and vision benefits: 211 CMR 52.12(1) through (4) and 211 CMR 52.12(11).

(14) A participating provider nurse practitioner practicing within the scope of his or her license, including all regulations requiring collaboration with a physician under

M.G.L. c. 112, §80B, shall be considered qualified within the carrier's definition of primary care provider to an insured.

(15) Contracts between carriers and health care providers shall recognize nurse practitioners as participating providers and shall treat services provided by participating provider nurse practitioners to their insureds in a nondiscriminatory manner for care provided for the purposes of health maintenance, diagnosis and treatment. Such nondiscriminatory treatment shall include, but not be limited to, coverage of benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his or her professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of healthcare licensed by the Commonwealth.

52.13: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. A carrier shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment:

(a) an evidence of coverage; or

(b) refer the insured to resources where the information described in such evidence of coverage can be accessed, including, but not limited to, an internet website. References to the terms, "internet website" shall include "intranet website" and "electronic mail" or "e-mail." An evidence of coverage in paper format shall always be delivered to the group representative in the case of a group policy.

(2) Evidences of Coverage as to Dental and Vision Carriers. Dental and vision carriers shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment:

(a) an evidence of coverage;

(b) a summary of the information contained in the evidence of coverage; or

(c) refer the insured to resources where the information described in such evidence of coverage can be accessed, including, but not limited to, an internet website.

Dental and vision carriers shall be exempt from the provisions of 211 CMR 52.13(3)(b), 211 CMR 52.13(3)(f), 211 CMR 52.13(3)(j) through (l) and 211 CMR 52.13(3)(q) through (a~~y~~)a).

(3) Evidence of Coverage Requirements. An evidence of coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.13(3)(a) through (aa)~~(y)~~.

(a) The health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law;
(b) The prepaid fee which must be paid by or on behalf of the insured and an explanation of any grace period for the payment of any health benefit plan premium;
(c) The limitations on the scope of health, dental or vision care services and any other benefits to be provided, including an explanation of any deductible or copayment feature;
(d) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health, dental or vision benefit plan;
(e) The locations where, and the manner in which, health, dental or vision care services and other benefits may be obtained;
(f) A description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;
(g) The criteria by which an insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(g) shall apply to carriers, including dental and vision carriers.
(h) The involuntary disenrollment rate among insureds of the carrier. 211 CMR 52.13(3)(h) shall apply to carriers, including dental and vision carriers.

1. For the purposes of 211 CMR 52.13(3)(h), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
2. For the purposes of 211 CMR 52.13(3)(h), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.

(i) The requirement that an insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.13(3)(i)1. through 5. 211 CMR 52.13(3)(i) shall apply to carriers, including dental and vision carriers.

1. failure by the insured or other responsible party to make payments required under the contract;
2. misrepresentation or fraud on the part of the insured;
3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3.;
4. relocation of the insured outside the service area of the carrier; or
5. non-renewal or cancellation of the group contract through which the insured receives coverage;

(j) A description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416;
(k) A statement telling insureds how to obtain the report regarding grievances pursuant to 105 CMR 128.600(A)(4) from the Office of Patient Protection;
(l) A description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;
(m) A description of the carrier's, including a dental or vision carrier's, method for resolving insured inquiries and complaints;
(n) A summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers. 211 CMR 52.13(3)(n) shall apply to carriers, including dental and vision carriers;
(o) A summary description of the utilization review procedures and quality assurance programs used by the carrier, including a dental or vision carrier, including the toll-free telephone number to be established by the carrier that enables consumers to determine the status or outcome of utilization review decisions;
(p) A statement detailing what translator and interpretation services are available to assist insureds, including that the carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish. 211 CMR 52.13(3)(p) shall apply to carriers, including dental and vision carriers.
(q) A list of prescription drugs excluded from any closed or restricted formulary available to insureds under the health benefit plan; provided, that the carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the carrier does all of the following:
    a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
    b. clearly states that all other prescription drugs are excluded;
    c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and
    d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

(r) A summary description of the procedures followed by the carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
(s) Requirements for continuation of coverage mandated by state and federal law;
(t) A description of coordination of benefits consistent with 211 CMR 38.00;

(u) A description of coverage for emergency care and a statement that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(v) If the carrier offers services through a network or through participating providers, the following statements regarding continued treatment:

1. If the carrier allows or requires the designation of a primary care ~~physician~~provider, a statement that the carrier will notify an insured at least 30 days before the disenrollment of such insured's primary care ~~physician~~ provider and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care provider~~physician~~ for at least 30 days after said provider ~~physician~~ is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative primary care ~~physician~~provider.

2. A statement that the carrier will allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

3. A statement that the carrier will allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

4. A statement that the carrier will provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a ~~physician~~provider who is not a participating provider in the carrier's network if:

   a. the insured's employer only offers the insured a choice of carriers in which said ~~physician~~provider is not a participating provider; and
   b. said ~~physician~~provider is providing the insured with an ongoing course of treatment or is the insured's primary care ~~physician~~provider; and
   c. With respect to an insured in her second or third trimester of pregnancy, 211 CMR 52.13(3)(v)4. shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, 211 CMR 52.13(3)(v)4. shall apply to services rendered until death;

5. A carrier may condition coverage of continued treatment by a provider under 211 CMR 52.13(3)(v)1. through 52.13(3)(v)4. upon the provider's agreeing as follows:

   a. to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost

sharing that could have been imposed if the provider had not been disenrolled;

b. to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and

c. to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier;

6. Nothing in 211 CMR 52.13(3)(v) shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider;

(w) If a carrier requires an insured to designate a primary care ~~physician~~provider, a statement that the carrier will allow the primary care ~~physician~~provider to authorize a standing referral for specialty health care provided by a health care provider participating in the carrier's network when:

1. the primary care ~~physician~~provider determines that such referrals are appropriate;

2. the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care ~~physician~~provider with all necessary clinical and administrative information on a regular basis;

3. the health care services to be provided are consistent with the terms of the evidence of coverage; and

4. Nothing in 211 CMR 52.13(3)(w) shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier;

(x) If a carrier requires an insured to obtain referrals or prior authorization from a primary care ~~physician~~provider for specialty care, a statement that the carrier will not require an insured to obtain a referral or prior authorization from a primary care ~~physician~~provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such carrier's health care provider network and that the carrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care ~~physician~~provider:

1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be medically necessary as a result of such examination;

2. maternity care;

3. medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions;

4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an insured's primary care ~~physician~~provider regarding the insured's condition, treatment, and need for follow-up care; and

5. Nothing in 211 CMR 52.13(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier; and

(y) A statement that the carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.13(3)(y), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.

(z) If a carrier allows or requires an insured to designate a primary care provider, a statement that the carrier shall provide the insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change his or her primary care provider to a participating provider nurse practitioner at any time during the insured's coverage period, if a participating provider nurse practitioner is available in the network.

(aa) A statement that the carrier will provide coverage on a nondiscriminatory basis for covered services when delivered or arranged for by a participating provider nurse practitioner.

(4) Internet Websites. If the carrier, including any dental or vision carrier, refers the insured to resources where the information described in the evidence of coverage can be accessed, including, but not limited to, an internet website, such carrier must be able to demonstrate compliance with the following with respect to the internet website, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The carrier has issued and delivered written notice to the insured that includes:

1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;

2. A list of the specific information to be furnished by the carrier through an internet website;

3. The significance of such information to the insured;

4. The insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;

5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and

6. A toll-free number for the insured to call with any questions or requests.

(b) The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to evidences of coverage shall apply to information and documents furnished by an internet website.

(c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.

(5) Group Plans. A carrier, including a dental and vision carrier, shall always deliver at least one evidence of coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 211 CMR 52.14, ~~or~~ 211 CMR 52.15, or 211 CMR 52.16.

(6) General Notice of Material Changes. A carrier, including a dental and vision carrier, shall provide to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all material changes to the evidence of coverage.

(7) Advance Notice of Material Modifications. A carrier, including a dental or vision carrier, shall issue and deliver to at least one adult insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health, dental or vision plan, at least 60 days before the effective date of the modifications. Such notices shall include the following:

(a) any changes in clinical review criteria; and

(b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

(8) Advance Filing of Evidence of Coverage. A carrier, including a dental or vision carrier, shall submit all evidences of coverage to the Bureau at least 30 days prior to their effective dates.

(9) Evidences of Coverage Used Prior to July 1, 2006. Carriers, including dental or vision carriers, may use evidences of coverage issued prior to 90 days after November 3, 2006 as if in compliance with 211 CMR 52.13. Evidences of coverage issued or renewed on or after 90 days after November 3, 2006 must comply with all of the requirements of 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13.

(10) Dates Required. Every evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

(11) Workers Compensation. A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.13 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(12) Certain Requirements Also Applicable to Evidences of Coverage for Dental and Vision Carriers. The following provisions of 211 CMR 52.13 shall also apply to evidences of coverage issued by dental and vision carriers: 211 CMR 52.13(4) through (10).

52.14: Required Disclosures for Carriers

(1) A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

(a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;

(b) a summary description of the process by which clinical guidelines and utilization review criteria are developed;

(c) the voluntary and involuntary disenrollment rate among insureds of the carrier;

1. For the purposes of 211 CMR 52.14(1)(c), carriers shall exclude all administrative disenrollments, insureds who are disenrolled because they have moved out of a health plan's service area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an insured has terminated coverage with the carrier for nonpayment of premium.

3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.

(d) ~~A~~a notice to insureds regarding emergency medical conditions that states all of the following:

1. that insureds have the opportunity to obtain health care services for an emergency medical condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an emergency medical condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

2. that no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and

4. if the carrier requires an insured to contact either the carrier or its designee or the primary care ~~physician~~provider of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care ~~physician~~provider by the attending emergency ~~physician~~provider shall satisfy that requirement.

(e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.1~~6~~7 is available to the insured or prospective insured from the Office of Patient Protection.

(f) a statement:

1. that an insured has the right to request referral assistance from a carrier if the insured or the insured's primary care provider has difficulty identifying medically necessary services within the carrier's network;

2. that the carrier, upon request by the insured, shall identify and confirm the availability of these services directly; and

3. that the carrier, if necessary, shall obtain or arrange for out-of-network services if they are unavailable within the network.

(2) The information required by 211 CMR 52.14 may be contained in the evidence of coverage and need not be provided in a separate document.

(3) Every disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date.

(4) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 days before their effective dates.

(5) Carriers shall submit material changes to the disclosures required by 211 CMR 52.14 to at least one adult insured in every household residing in Massachusetts at least once every two years.

(6) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.14 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(7) A carrier, including a dental or vision carrier, shall provide to a health, dental or vision care provider, a written reason or reasons for denying the application of any health, dental, or vision care provider who has applied to be a participating provider.

(8) A carrier for whom a behavioral health manager is administering behavioral health services shall state on its new enrollment cards issued in the normal course of business, within one year, the name and telephone number of the behavioral health manager.

52.15: Required Disclosures for Behavioral Health Managers

(1) A behavioral health manager shall provide the following information to at least one adult insured in each household covered by their services:

(a) a notice to the insured regarding emergency mental health services that states:

1. that the insured may obtain emergency mental health services, including the option of calling the local pre-hospital emergency medical service

system by dialing the 911 emergency telephone number or its local equivalent, if the insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;

2. that no insured shall be discouraged from using the local pre-hospital emergency medical service system, the 911 emergency telephone number or its local equivalent;

3. that no insured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and

4. if the behavioral health manager requires an insured to contact either the behavioral health manager, carrier or primary care provider of the insured within 48 hours of receiving emergency services, notification already given to the behavioral health manager, carrier or primary care provider by the attending emergency provider shall satisfy that requirement;

(b) a summary of the process by which clinical guidelines and utilization review criteria are developed for behavioral health services; and

(c) a statement that the Office of Patient Protection, is available to assist consumers, a description of the grievance and review processes available to consumers, and relevant contact information to access the office and these processes.

(2) The information required by 211 CMR 52.15(1) may be contained in the carrier's evidence of coverage and need not be provided in a separate document. Every disclosure described in this section shall contain the effective date, date of issue and, if applicable, expiration date.

(3) A behavioral health manager shall submit a material change to the information required by 211 CMR 52.15(1) to the Bureau at least 30 days before its effective date and to at least one adult insured in every household residing in the Commonwealth at least biennially.

(4) A behavioral health manager that provides specified services through a workers' compensation preferred provider arrangement that meets the requirements of 211 CMR 112.00 and 452 CMR 6.00 shall be considered to comply with this section.

(5) A carrier for whom a behavioral health manager is administering behavioral health services shall be responsible for the behavioral health manager's failure to comply with the requirements of this chapter in the same manner as if the carrier failed to comply and shall be subject to the provisions of 211 CMR 52.18.

52.165: Provider Directories

(1) A carrier shall deliver a provider directory to at least one adult insured in each household upon enrollment and to a prospective or current insured upon request. Annually, thereafter, a carrier shall deliver to at least one adult insured in each household, or in the case of a group policy, to the group representative, a provider directory. The carrier may deliver a provider directory through an internet website. References to the term "internet website" shall include "intranet websites" and "electronic mail", or "e-mail".

(a) The provider directory must contain a list of health care providers in the carrier's network available to insureds residing in Massachusetts, organized by specialty and by location and summarizing for each such provider the method used to compensate or reimburse such provider.

1. Nothing in 211 CMR 52.165(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a carrier and a provider.

2. A carrier will be deemed to be in compliance with 211 CMR 52.165(1)(a) if the method of compensation is identified at least as specifically as "fee-for service" or "capitation."

3. If any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

4. Notwithstanding any general or specific law to the contrary, a carrier shall ensure that all participating provider nurse practitioners are included and displayed in a nondiscriminatory manner on any publicly accessible list of participating providers for the carrier.

(b) The provider directory must contain a toll-free number that insureds can call to determine whether a particular health care provider is affiliated with the carrier.

(c) The provider directory must contain an internet website address or link that insureds can visit to determine whether a particular provider is affiliated with the carrier.

(d) If the carrier refers an insured to access provider directory information through an internet website, the carrier must be able to demonstrate compliance with the following:

1. The carrier has issued and delivered written notice to the insured that includes:

a. All necessary information and a clear explanation of the manner by which insureds can access their specific provider directory through an internet website;

b. A list of the specific information to be furnished by the carrier through an internet website;

c. The significance of such information to the insured;

d. The insured's right to receive, free of charge, a paper copy of the provider directory at any time;

e. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and

f. A toll-free number for the insured to call with any questions or requests.

2. The carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents.

3. All notice and time requirements applicable to evidences of coverage shall apply to information and documents made available by Internet. Information contained in the documents furnished in an internet website shall include the effective date and the published date of any updates, modifications or material changes.

4. The carrier updates the website as soon as practicable.

5. In the case of a group policy, the carrier delivers a paper copy of the provider directory to the group representative.

6. The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of the provider directory.

~~(2) Carriers that delivered provider directories prior to January 1, 2001 shall be deemed to have met the requirements of 211 CMR 52.15(1) if during the year between July 1, 2001 and June 30, 2002 the carrier delivers a provider directory to at least one adult insured in each household and to any new enrollee on or after July 1, 2001.~~

(~~3~~2) A carrier shall not be required to deliver a provider directory upon enrollment if a provider directory is delivered to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

(3)~~I~~ If delivering a paper copy of the provider directory, a carrier shall be deemed to have met the requirements of 211 CMR 52.16~~5~~(1) if the carrier:

(a) provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the provider directory originally provided under 211 CMR 52.16~~5~~(1); and

(b) updates its toll-free number within 48 hours and internet website as soon as practicable.

(4) Every provider directory described in 211 CMR 52.16~~5~~ must contain the effective date, date of issue and expiration date, if applicable.

(5) ~~(6)~~ A carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.16~~5~~ if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.176: Material to be Provided to the Office of Patient Protection

(1) A carrier shall provide the following to the Office of Patient Protection at the same time the carrier provides such material to the Bureau of Managed Care:

(a) A copy of every evidence of coverage and amendments thereto offered by the carrier.
(b) A copy of the provider directory described in 211 CMR 52.156.
(c) A copy of the materials specified in 211 CMR 52.14 and 211 CMR 52.15.

(2) A carrier shall provide the following to the Office of Patient Protection by no later than April 1st:

(a) A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the carrier.
(b) A report of the percentage of ~~physician~~providers who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary ~~physician~~provider disenrollment;
1. For the purposes of 211 CMR 52.176(2)(b) carriers shall exclude ~~physician~~providers who have moved from one physician group to another but are still under contract with the carrier.
2. For the purposes of 211 CMR 52.176(2)(b) "voluntarily terminated" means that the ~~physician~~provider terminated its contract with the carrier.
3. For the purposes of 211 CMR 52.176(2)(b) "involuntarily terminated" means that the carrier terminated its contract with the ~~physician~~provider.
(c) The percentage of premium revenue expended by the carrier for health care services provided to insureds for the most recent year for which information is available; and
(d) A report detailing, for the previous calendar year, the total number of
1. filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and
2. external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such insureds, which shall include, but need not be limited to, race, gender and age.
(e) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.176(1)(a), (b), and (c) and 211 CMR 52.176(2)(c) and (d).

52.187: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a finding of neglect on the part of a carrier, the Commissioner shall notify the carrier in writing that the carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the carrier $5000 for each day during which the neglect continues.

Following notice and hearing, the Commissioner shall suspend the carrier's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

(2) Noncompliance with Accreditation Standards Set Forth in 211 CMR 52.00.

(a) Investigation. The Bureau shall investigate all complaints made against a carrier or any entity with which it contracts for allegations of noncompliance with the accreditation requirements established under 211 CMR 52.00.

(b) Notice. The Bureau shall notify a carrier when, in the opinion of the Bureau, complaints made against a carrier or any entity with which it contracts indicate a pattern of noncompliance with a particular requirement. The notice shall detail the alleged noncompliance and establish a hearing date for the matter.

(c) Hearing Held Pursuant to 211 CMR 52.187(2)(b).

1. The hearing shall be held no later than 21 days following the date of the notice specified in 211 CMR 52.187(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.187(2)(c), the Bureau may issue a finding against the carrier, including but not limited to:

1. An order requesting a corrective action plan and timeframe to achieve compliance.
2. A reprimand or censure of the carrier.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the carrier's accreditation.

(3) Action by a National Accreditation Organization. If a national accreditation organization takes any action to revoke the accreditation or otherwise limit or negatively affect the accreditation status of a carrier, or any entity with which a carrier contracts for services subject to M.G.L. c. 176O, the carrier must notify the Bureau within two days and shall specify the action taken and the reasons given by the national accreditation organization for such action.

(4) Revocation by a National Accreditation Organization. If the national accreditation organization revokes accreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the carrier's accreditation.

(5) Informal Resolutions. Nothing in 211 CMR 52.187 shall be construed to prohibit the Bureau and a carrier from resolving compliance issues through informal means.

52.1~~98~~: Severability

If any provision of 211 CMR 52.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 52.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected ~~thereby~~.

~~52.100: *Appendix A*, THROUGH THE END OF THE REGULATION.Remove in accordance with new incorporation by reference.~~